

Neurobehavioral Symptom Inventory (NSI)

Please rate the following symptoms with regard to how much they have disturbed you IN THE LAST 2 Weeks.
The purpose of this inventory is to track symptoms over time. Please do not attempt to score.

0 = None – Rarely if ever present; not a problem at all

1 = Mild – Occasionally present, but it does not disrupt my activities; I can usually continue what I'm doing; doesn't really concern me.

2 = Moderate – Often present, occasionally disrupts my activities; I can usually continue what I'm doing with some effort; I feel somewhat concerned.

3 = Severe – Frequently present and disrupts activities; I can only do things that are fairly simple or take little effort; I feel I need help.

4 = Very Severe – Almost always present and I have been unable to perform at work, school or home due to this problem; I probably cannot function without help.

Symptoms	0	1	2	3	4
Feeling Dizzy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of balance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor coordination, clumsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vision problems, blurring, trouble seeing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sensitivity to light	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing difficulty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sensitivity to noise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Numbness or tingling on parts of my body	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Change in taste and/or smell	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of appetite or increased appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor concentration, can't pay attention, easily distracted	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Forgetfulness, can't remember things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty making decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Slowed thinking, difficulty getting organized, can't finish things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue, loss of energy, getting tired easily	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty falling or staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling anxious or tense	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling depressed or sad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritability, easily annoyed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor frustration tolerance, feeling easily overwhelmed by things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Date:

Name:

Medical Record #: